IMMUNIZATION SCREENING & CONSENT FORM

Flu • Pneumonia • Shingles • Tdap

PATIENT INFORMATION

Name: ______________________ DOB: __________ Age: ________

Address: ______________________ City / State / Zip: __________

Phone: ______________________ Email: __________

Primary Care Physician: ______________________ Phone: __________

Eligible for Medicare? **YES / NO** Medicare ID: __________ SSN: __________

If no Medicare, please provide insurance information: Name of Plan: __________

BIN: __________ PCN: __________ ID: __________ Group: __________

Please select the vaccine you are interested in receiving:

- ☐ **Flu**
- ☐ **Pneumonia**
- ☐ **Shingles**
- ☐ **Tetatnus, Diphtheria, Pertussis**
- ☐ **Other:** __________

PHARMACY USE

☐ Flucelvax Quad(4+)	☐ Shingrix
☐ Afluria Quad(4+)	☐ Prevnar (PCV13)
☐ Fluzone Quad HD (65+)	☐ Pneumovax (PPSV23)
☐ Fluad Quad(65+)	☐ Tdap (Boostrix)

Series: ☐ *1st Dose* ☐ *2nd Dose*

SCREENING QUESTIONNAIRE: *The following questions will help us determine your eligibility to be vaccinated today.*

1. Are you feeling sick or experiencing a fever today? **YES / NO**
2. Do you have an allergy to **eggs**, **Thimerosal**, **latex**, or to a component of a vaccine? **YES / NO**
   If yes, please list allergy and reaction:
3. Have you ever had a serious reaction to any vaccination, including fainting, dizziness or shortness of breath? **YES / NO**
4. Do you have cancer, leukemia, HIV/AIDS, or any condition that weakens the immune system? **YES / NO**
5. Do you take cortisone, prednisone, other steroids, anticancer drugs, or have you had any radiation treatments? **YES / NO**
6. Have you ever had a seizure disorder requiring seizure medication(s), a brain disorder, or Guillain-Barre Syndrome (a condition that causes paralysis)? **YES / NO**
7. Have you received any vaccinations within the past four weeks? **YES / NO**
   If yes, please list vaccine and date given:

For children between ages 4 and 8: Have you received a flu vaccine before? **YES / NO**
If yes, please list when received:

For Women: Are you pregnant or considering becoming pregnant within the next month? **YES / NO**

SHINGLES VACCINE ONLY:
Have you had chickenpox? **YES / NO**
Have you ever been diagnosed or treated for shingles? **YES / NO**
If yes, when were you treated?

PNEUMONIA VACCINE ONLY:
Have you ever received a pneumonia vaccine? **YES / NO**
If yes, when?

By signing this form, I agree to be vaccinated today by El Dorado TrueCare Pharmacy. I have received and understand information about the vaccines designated above. I have had my questions answered to my satisfaction. I authorize the provider performing the service to release and access from my insurer (if applicable) and primary health care provider any medical or other information necessary. I give my consent for information contained on this form to be released to the Kansas Immunization Program for the purpose of assessment and reporting. I authorize the payment of medical benefits to the provider performing the service. If I have a copayment or the vaccine is not covered on my insurance, I will remit payment to El Dorado TrueCare Pharmacy.

Signature: **Date:**

Flu Vaccine/	Prevnar/	Pneumovax/	Shingrix/	Boostrix (Tdap)/
L / R	L / R	L / R	L / R	L / R
Lot	Lot	Lot	Lot	Lot
Exp	Exp	Exp	Exp	